



The Role of the Patient Aligned Care Team Social Worker

**At the Community Based Outpatient Clinics
(CBOC)**

Shawn Richardson, LCSW

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Tennessee Valley Healthcare System Community Based Clinics



- Chattanooga, TN (PACT/MH)
- Clarksville, TN (PACT/MH)
- Tullahoma, TN (PACT)
- McMinnville, TN (MH)
- Bowling Green, KY (MH)
- Athens, TN (MH)
- Hopkinsville, KY (MH)
- Dover, TN (PACT)
- Cookeville, TN (PACT/MH)
- Harriman, TN (PACT/MH)
- Columbia, TN (PACT/MH)

NOTE: There are Nashville VA Clinics at MeHarry Medical College and on Charlotte Ave.

NOTE: Each VAMC maintains Primary Care Clinics.

NOTE: Dover clinic Veterans gain mental health services at the Clarksville Clinic.

NOTE: Tullahoma clinic Veterans gain some mental health services from VAMC in Murfreesboro and some using Tele-Mental Health.

CBOC Social Work Services



- All social workers are licensed at the master's level.
- Employer:
 - A. Contractor
 - B. Full-time or Part-time VA employee.



Role of the Social Worker in the PACT

- Identify Veterans at high risk for psychosocial complications
- Provide pro-active intervention
 - Eliminate barriers to health care interventions
 - Offer strategies to resolve underlying causal factors
 - Build upon and promote strengths and abilities
- Educate and motivate Veteran/Caregiver toward health promotion, disease prevention and management of self
- Follow Veteran/Caregiver through continuum of health care
- Support PACT Team members with challenging patient-care situations
- Collaborate and interface with other Specialty Case Management Programs, i.e. Post Deployment Patient Primary Care Clinics, Polytrauma, SCI, Geriatrics, Home Based Primary Care, Mental Health, and Homeless Programs

Core Components of Social Work





What Does Social Work Offer to Veterans, Families?

- Consultation and education
- Psychosocial assessment
- Training and coaching (for staff and patients/caregivers)
- Interdisciplinary shared decision making
- Vital linkages to VA/community resources and support



Psychosocial Complications

- Low income
- Frail/elderly
- Frequent hospitalization & ED visits
- Active substance abuse
- Multiple moves over short time (unstable housing)
- Diagnosis based or chronic illness (heart Disease Congestive Heart Failure, Stroke, Cancer, Severe Arthritis, uncontrolled Hypertension, Diabetes, Degenerative Neurological Disorders, Catastrophic illness or injury etc)
- Limited or no support system



Inpatient to Outpatient Transitions

- PACT SW will identify high risk cohorts for early intervention to prevent inpatient stays due to psychosocial issues
- PACT SW Case Manager will collaborate with inpatient SW when high risk pts are admitted and collaborate in discharge planning of Veterans at high risk for re-admission due to psychosocial or environmental issues to provide seamless continuity of care.
- PACT SW Case Manager will coordinate with Teamlet RN Care Manager to ensure needed services are ordered post-discharge

Social Work Assessment and Intervention in the Patient Aligned Care Team



- Work with the PACT team to identify psychosocial complications for preventive intervention
- Referral to PACT Social Work Case Management
 - Educate Teamlet, team, in-house programs, and external agencies on criteria for referral
- Triage assessment
- Comprehensive psychosocial assessment
- Advocacy
- Communicate psychosocial tx plan with team members
- Psychosocial interventions



Comprehensive Social Work Assessment

- Six domains with corresponding level of intervention based upon assessed acuity
 - access to care
 - economics
 - housing
 - psychological status
 - social support
 - functional status

Automatic Social Work Assessment



- Returning combat Veteran new to VA/clinic (OIF/OEF/OND)
- Homelessness
- Catastrophic or terminal illness or injury
- Veterans who have declining health due to psychosocial barriers
 - medication
 - surgeries
 - physical exam
- Veterans showing signs of abuse, neglect, exploitation or cognitive problems

Overall Benefits of the PACT SW at the CBOCs



- Supports RN Care Manager with coordination of care
- Early identification of psychosocial issues
- Early education and intervention
- Encourages exploration of alternatives to care
- Reduces risk for hospitalization or institutionalization
- Reduction in utilization of health care resources
- Helps monitor the status of the Veteran between provider contacts
- Enhances connection to Veteran's local community



Communication Strategies

- Identify your assigned PACT Team Social Worker
- How do you reach the Social Worker?
 - Backup Coverage
- Identify Social work Availability
 - General Availability
 - Urgent Availability
- Walk-in Visits / Schedule

The Tullahoma CBOC is on a secure military base. Please call the Social Worker ahead of time and she will arrange access to the clinic.



QUESTIONS?